TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nueva Vida Behavioral Health

Respondent Name
Alamo Community College District

MFDR Tracking Number
M4-13-2908

Carrier's Austin Representative
Box Number 16

MFDR Date Received
July 1, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Prior Authorization was obtained for all the services we provided, which were medically necessary in aiding the patient recovery for the work related compensable injury…"

Amount in Dispute: $135.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent would show that Requestor is not entitled to reimbursement for the services at issue, because such services do not represent reasonable and necessary medical treatment for the compensable injury."

Response Submitted by: Adami, Shuffield, Scheihing, & Burns

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2013	90837	$135.00	$135.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets outs the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 561 – According to the state fee schedule, this procedure code is not considered a valid reimbursable code
   - 216 – Based on the findings of a review organization
   - 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 216 – "Based on the findings of a review organization." 28 Texas Administrative Code §134.600 (l) states,

   > The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued. The approval shall include:
   >
   > (1) the specific health care;
   >
   > (2) the approved number of health care treatments and specific period of time to complete the treatments;
   >
   > (3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury; and
   >
   > (4) the insurance carrier's preauthorization approval number that conforms to the standards described in §19.2009(a)(4) of this title (relating to Notice of Determinations Made in Utilization Review).

   Review of the submitted documentation finds:

   - Document dated December 4, 2012 from Sedgwick CMS
   - Medically Certified Individual Psychotherapy x 6 sessions over 6 weeks
   - Start date: 11/29/2012 End date: 2/4/2013
   - "specific service meets established criteria for medical necessity …"

   The Division finds the carrier's denial is not supported furthermore 28 Texas Administrative Code 134.600 (c) states,

   > The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:
   >
   > (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   >
   > (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

   Review of the submitted documentation finds authorization was given thus the carrier is liable. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (c) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The services in dispute will be calculated as follows;

- Procedure code 90837, service date February 1, 2013. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.83 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.83. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 0.912 is 0.48336. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.809 is 0.08899. The sum of 3.40235 is multiplied by the Division conversion factor of $55.30 for a MAR of $188.15. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $135.00.

3. The total allowable reimbursement for the services in dispute is $135.00. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $135.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $135.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $135.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.